

responsible for applicable Medicare deductible and coinsurance amounts, unless the HMO's or CMP's charges for these amounts are reduced under the additional benefits provision of § 417.442.

(2) The deductible and coinsurance amounts may be paid by or on behalf of the enrollee in the form of a premium, membership fee, charge per unit, or other similar charge.

(3) The sum of the amounts the HMO or CMP charges its Medicare enrollees for Medicare deductibles and coinsurance may not exceed, on the average, the actuarial value of the deductible and coinsurance the Medicare enrollees otherwise would have been liable for had they not enrolled in the HMO or CMP or in another HMO or CMP.

(b) *Services not covered under Medicare.* Unless the services are provided as additional benefits under § 417.442, a Medicare enrollee of an HMO or CMP is liable for payment for—

(1) All services that are not covered under Medicare Part A or Part B; or

(2) If entitled only to Medicare Part B benefits, all services that are not covered under Medicare Part B.

(c) *Services for which Medicare is not primary payer.* A Medicare enrollee of an HMO or CMP is liable for payments made to the enrollee for all covered services for which Medicare is not the primary payer as provided in § 417.528.

(d) *Optional supplemental benefits plan.*

(1) The HMO or CMP may offer its Medicare enrollees a supplemental benefit plan to cover deductible and coinsurance amounts, or services not covered under Medicare, or both.

(2) If a supplemental benefit plan premium includes charges for both non-covered services and the deductible and coinsurance amounts applicable to covered services, the portion of the premium that is for deductibles and coinsurance must be computed separately and must be disclosed to the beneficiary during the enrollment process and before he or she elects coverage options.

(3) The sum of the amounts an HMO or CMP charges its Medicare enrollees for services that are not covered under Part A or Part B may not exceed the ACR for these services.

(e) *Coverage of Part A services for Part B-only Medicare enrollees.* If an HMO or CMP furnishes coverage of Medicare Part A services to a Medicare enrollee entitled to Part B only, the HMO's or CMP's premium (or other payment method) for these services may not exceed the ACR for these services. In addition, if a risk HMO or CMP furnishes these services and supplemental services, which are the same as the additional benefits furnished Medicare enrollees of the HMO or CMP who are entitled to benefits under both Parts A and B, the HMO's or CMP's combined premium for both these groups of services that the Part B enrollee must pay may not exceed 95 percent of the weighted average AAPCC for Part A services (or the Medicare payment for Part A services, if it is less) for the Medicare enrollee of the HMO or CMP.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38079, July 15, 1993; 60 FR 45678, Sept. 1, 1995]

§ 417.454 Charges to Medicare enrollees.

(a) *Limits on charges.* The HMO or CMP must agree to charge its Medicare enrollees only for the—

(1) Deductible and coinsurance amounts applicable to furnished covered services;

(2) Charges for noncovered services or services for which the enrollee is liable as described in § 417.452; and

(3) Services for which Medicare is not the primary payor as provided in § 417.528.

(b) *Limit on charges for inpatient hospital care.* If a Medicare enrollee who is an inpatient of a hospital requests immediate PRO review (as provided in § 417.605) of any determination by the hospital furnishing services or the HMO or CMP that the inpatient hospital services will no longer be covered, the HMO or CMP may not charge the enrollee for any inpatient care costs incurred before noon of the first working day after the PRO issues its review decision.

(c) *Reporting requirements.* A risk HMO or CMP must report, within 90 days after the end of the contract period, all premiums, enrollment fees,

§417.456

42 CFR Ch. IV (10–1–00 Edition)

and other charges collected from its Medicare enrollees during that period.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 59 FR 59941, Nov. 21, 1994; 60 FR 45678, Sept. 1, 1995]

§417.456 Refunds to Medicare enrollees.

(a) *Definitions.* As used in this section—

Amounts incorrectly collected means amounts collected that are in excess of those specified in §417.452. It includes amounts collected when the enrollee was believed not entitled to Medicare benefits if the enrollee is later determined to have been entitled to Medicare benefits and HCFA is liable for payments as specified in §417.450.

Other amounts due means amounts due a Medicare enrollee for services obtained outside the HMO or CMP if they were—

- (1) Emergency services;
- (2) Urgently needed services for which the HMO or CMP has assumed financial responsibility; or
- (3) On appeal under subpart Q of this part, found to be services the enrollee was entitled to have furnished by the HMO or CMP.

(b) *Basic commitment.* An HMO or CMP must agree to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and any other amounts due the enrollees or others on their behalf.

(c) *Refund by lump sum payment.* An HMO or CMP must make refunds to its current and former Medicare enrollees, or to others who have made payments on behalf of enrollees, by lump sum payment for the following:

- (1) Incorrectly collected amounts that were not collected as premiums.
- (2) Other amounts due.
- (3) All amounts due, if the HMO or CMP is going out of business.

(d) *Refund by premium adjustment or lump sum payment or both.* An HMO or CMP may make refund by adjustment of future premiums, by lump sum payment, or by a combination of both methods, for amounts that were incorrectly collected in the form of premiums or through a combination of premium payments and other charges.

(e) *Refund when enrollee has died or cannot be located.* If an enrollee has died or cannot be located after reasonable effort by the HMO or CMP, the HMO or CMP must make the refund in accordance with State law.

(f) *Reduction by HCFA.* If the HMO or CMP does not make refund in accordance with paragraphs (b) through (d) of this section by the end of the contract period following the contract period during which an amount was determined to be due an enrollee, HCFA reduces its payment to the HMO or CMP by the amounts incorrectly collected or otherwise due, and arranges for those amounts to be paid to the Medicare enrollee.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38079, July 15, 1993; 60 FR 45678, Sept. 1, 1995]

§417.458 Recoupment of uncollected deductible and coinsurance amounts.

An HMO or CMP agrees not to recoup deductible and coinsurance amounts for which Medicare enrollees were liable in a previous contract period except in the following circumstances:

(a) The HMO or CMP failed to collect the deductible and coinsurance amounts during the contract period in which they were due because of—

- (1) Underestimation of the actuarial value of the deductible and coinsurance amounts; or
- (2) A billing error.

(b) The HMO or CMP has identified the amounts and obtained advance HCFA approval of the recoupment and the method and timing of recoupment.

(c) The HMO or CMP collects these amounts no later than the end of the contract period following the contract period during which they were found to be due.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 45678, Sept. 1, 1995]

§417.460 Disenrollment of beneficiaries by an HMO or CMP.

(a) *General rule.* Except as provided in paragraphs (b) through (i) of this section, an HMO or CMP may not—

- (1) Disenroll a Medicare beneficiary; or